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Health and Brexit

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Introduction

Following the UK's vote to leave the European Union in the referendum of 23rd June 2016, we surveyed 100 health economists regarding their opinions on 'Brexit'. Researchers have started to consider the challenges of Brexit (Oxford Review of Economic Policy, 2017). However the impact on health and health services is often not directly considered. The NHS has always been a political 'football' and the EU referendum campaign was no exception. The "£350m-a-week" for the NHS claim, made during campaigning, was one of the most eye-catching elements of the *Vote Leave* message. However, as predicted by many commentators, this claim has been watered down following the vote to leave.

With Article 50 triggered on 29th March, now is a valuable time to report on those views and the challenges that Brexit may pose. Academics and policy leaders (dare we call them "experts"?) are a rich source for considering where the benefits and challenges for the NHS lie and how, potentially, we can optimise the benefits and ameliorate the impact of the challenges – especially with no historical precedent to call on (*as ibid*). Even though all of our respondents (59% response rate) were in favour of remaining in the EU, they identified positives and negatives, with a key focus on the labour force and the single market.

The survey

We used Survey Monkey to elicit the views of 100 senior health economists (including economists with an interest in health) between 12th Oct and 22nd Oct 2016. The selection, which focussed on researchers from universities and policy think-tanks, was guided by the IDEAS-Research Papers in Economics Top Economists in the Field of Health Economics (<https://ideas.repec.org/top/top.hea.html>).

We surveyed economists from outside (the US, Canada and Australia) and inside the EU (including England and Wales, Scotland and Northern Ireland) and received 59 responses.

Open-ended questions were used to generate ideas and gather a range of views. There was no attempt to represent a population, adjust for response selection, or estimate the prevalence or strength of views. We report a basic thematic analysis which we integrate with discussion, adding context to the issues raised by respondents. The questions posed were:

- Thinking of health and health services in the UK, describe up to three POSITIVE outcomes that may arise from Brexit.
- Thinking of health and health services in the UK, describe up to three NEGATIVE outcomes that may arise from Brexit.

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- Thinking of health and health services in the UK, if you were advising the UK Government on Brexit negotiations what would be the ONE key issue in the negotiations that you would insist upon, and why?
- In what ways will Brexit affect research in health and health care funding and delivery?

Emerging themes

Responses could be categorised into two main themes: issues relating to the economy (and the single market) and issues relating to labour markets. It is unsurprising, given the whole nature of the Brexit debate, that growth/recession and immigration dominate the concerns.

The economy, health and health services

The role of the economy for health is vital, with health spending being closely linked to GDP. Any Brexit consequences on the economy will affect spending on the NHS. ‘...if Brexit turned out to be good for the economy, then more growth [would lead to] more money for the NHS.’ However, if a recession occurs, or if growth is lower than expected (or lower than it would have been without Brexit), then “NHS expenditure will suffer”. Austerity has already seen NHS spending increases at their lowest level for some time, with funding barely increasing in real terms between 2010 and 2015 (King’s Fund, 2015).

What must also be considered, but was not raised by any respondent, is that the EU is not immune to these changes. Health spending in the EU will also respond to the economic changes and will have health consequences across Europe. Although the link between recessions and health is debated (Ruhm, 2005, 2015), a considerable literature positively links income and health (Case et al., 2002). It is possible that Brexit will lead to a slowing in economic growth across the globe. With the UK Government saying that it will not look to stay in the single market, key trade deals will need to be negotiated to ensure that the economies of the UK and Europe do not suffer.

In terms of exports, our respondents viewed the depreciation of the pound as a positive. With the UK as one of the largest exporters of pharmaceutical products in the world, any benefits in the export market will add value to the economy. The outlook for pharmaceuticals post-Brexit may be strong given the recent announcements by Novo Nordisk and GlaxoSmithKline of large investments in the UK, suggesting that fears regarding the Brexit vote may not be as large as some experts fear. Respondents did note, however, that the loss of the European Medicines Agency will mean that new regulatory and evaluations frameworks will need to be put in place, with, as one respondent noted, “huge implications for clinical trials”.

For utilisation and health, several respondents highlighted the possibility of a “reduction in pressure on NHS services due to reduced demand” and that health may improve due to “greater security”. However, many raised the possibility of “long waiting times” and, more gloomily “...evidence shows that natural disasters affect mental health; this political disaster will be no different”.

The direction of the political debate also matters. If the Government does, as a respondent hoped, “take the plight of the deprived regions more seriously” and use the post-Brexit political landscape to rebalance the economy, focus on those ‘just about managing’ (JAMs) and tackle social inequalities, then population health may improve. If social inequalities narrow, and the relative income hypothesis of Wilkinson (1996) holds true, then the UK could benefit.

If however, as many of our respondents feared, social inequality widens, “increase[ing] health inequalities through economic troubles”, and more divisions arise due to a “rise in nationalism and

isolationism”, then the same arguments could be used to suggest widening health inequalities and falling population level health.

Sovereignty - “the ability to maintain an NHS (if we want)” - and trade deals were other key issues raised by our respondents. The Trans-Atlantic Trade and Investment Partnership (TTIP), although now seemingly dead in the water, potentially threatened the NHS and EU publicly funded health services. Being outside of the EU may provide greater scope for protecting the NHS and retaining a health service that reflects the values of the population. However, it was interesting to note that none of the respondents suggested that bi-lateral trade deals may include pressure to open the NHS to international private interests. It is also worth noting that the Canadian agreement with the EU, which the UK is still signed up to, also enables private firms to access UK markets as long as they have a base in Canada.

Health (and academic) human resources

The labour market was a major concern among respondents. The NHS – and the social care sector - are heavily dependent on migrant labour. With the UK Government committed to restricting the free movement of labour, there will be staffing challenges in an over-worked and low-morale sector. The promise of a points-based system may allow for the targeting of high skilled workers, such as doctors and the more highly trained health professionals. However it may be much harder to attract, and allow entry to, sufficient numbers of middle and low-skilled workers (Migration Observatory, 2017). Such problems will be exacerbated if immigration targets lead to caps on overseas recruitment - for instance, nurses are already considered a shortage profession but have a cap on the number of non-EU recruits. The NHS could previously circumvent this cap by recruiting nurses from Europe; a route that may no longer be available post-Brexit.

In response to the labour market challenges, some respondents noted the possibility of a greater focus on training health professionals domestically. In the wake of the Brexit vote, the Government immediately announced a rise in the number of training places for doctors, and changes have been made to the funding system for training nurses, with the (currently forlorn) hope that it will increase the numbers in training. Increasing the skills and education of the native workforce was considered to be positive by many health economists and could benefit health, productivity and the economy more widely. Similarly, it should be noted that immigration changes may provide some benefits for the countries that provide many NHS staff. If fewer skilled people - and often migrants are over skilled for the level of work they take on in their destination countries - leave their native countries, then they may boost the levels of the skilled workforce in countries that are often still developing.

Respondents were fearful of the impact of Brexit on health research. This is clearly going to be a challenging area for the Government post-Brexit. Most respondents acknowledged the impact on research funding that will result from the loss of EU funding streams. But more important concerns were raised about Brexit limiting the opportunities for international research collaborations and consortia, - the sharing of ideas, research competition and the ability to undertake comparative analysis - with medical research, health service research and socio-economic research all suffering, in both the UK and the EU. Although such fears may be partly compensated by the announcement of Global Challenge Initiatives, funding that aims to build capacity through partnerships with low- and middle-income countries, rather than collaboration with partners who are already internationally recognised.

The challenges for the UK research sector are particularly stark. With the UK reliant on so many EU researchers, whose positions in the UK are not guaranteed, there is a risk of a ‘brain drain’. With

labour market restrictions that may arise from a new immigration policy, recruitment and retention of skilled researchers may become difficult as the “UK won’t be attractive to good Europeans”. A further problem may be that UK academics, who were largely against Brexit, may also choose to leave the UK - although Trump's America may currently also seem unattractive!

Conclusion

Brexit poses many challenges. Regarding positives, many respondents felt there were “none”. For the negotiations, our respondents placed great importance on the single market and the free movement of labour (more than one wrote “don’t do it”), although we now know that the Government will not commit to these. However, potential positives, that need to be built upon, were identified.

Ultimately, Brexit presents a challenge for academia itself. None of our respondents voted (or, if they were not eligible, stated that they would have voted) to leave. Many of the responses were angry at the decision to vote leave. While it is vital that the academic health economics profession continues to make the arguments, whether they are pro-leave or pro-remain, it is important that we do not lose sight of the fact that Brexit is happening and we, as academics, need to consider Brexit objectively, by researching it, and asking questions of it, as we would any other change. As Hamlet might have put it, “there is nothing either good or bad, but thinking makes it so”. Intended and unintended consequences, positive and negative, will arise; the academic profession will only have something meaningful to say if it can research these fairly and without bias. Furthermore, the profession needs to find ways to make Brexit, whatever it finally looks like, work - contributing to the policy debate and the research literature with the aim of benefitting society. In this respect, we already have strengths in place within health economics to guide research into the implications for health inequalities, health human resources and the nexus of trade and health policy.

Case, A., Lubotsky, D. and Paxson, C. (2002) Economic Status and Health in Childhood: The Origins of the Gradient, *The American Economic Review*, 92, 1308-1334

King’s Fund (2015) *NHS spending: squeezed as never before*,
<https://www.kingsfund.org.uk/blog/2015/10/nhs-spending-squeezed-never>

Migration Observatory (2017) *Labour Immigration after Brexit: Trade-offs and Questions about Policy Design*, University of Oxford, Oxford

Oxford Review of Economic Policy (2017) *The Economics of Brexit* Supplementary Issue, Vol 33

Ruhm, C.J. (2000) Are recession good for your health? *Quarterly Journal of Economics*, 115, 617-650

Ruhm, C.J. (2015) Recessions healthy no more?, *Journal of Health Economics*, 42, 17-28

Wilkinson, R. (1996) *Unhealthy Societies*, Routledge, London